CHAPTER 5: INDUSTRY SNAPSHOT: INSURANCE AND OTHER THIRD PARTY PAYMENT PROGRAMS

CHAPTER 5: INDUSTRY SNAPSHOT: INSURANCE AND OTHER THIRD PARTY PAYMENT PROGRAMS

I. OVERVIEW

Chapter 5 provides an introduction to health insurance, including the applicable regulatory framework and sources of health care coverage. Chapter 6 summarizes competition law as it applies to the health insurance industry and then analyzes current controversies, including most favored nation clauses, mandated benefits, and consumer directed health plans.

Representatives from insurance groups and organizations, as well as legal, economic, and academic experts, spoke at the Hearings on insurance-related panels, including: Health Insurance: Payor/Provider Issues (September 9, 2002); Health Insurance Monopoly Issues: Market Definition (April 23); Health Insurance Monopoly Issues: Competitive Effects (April 23); Health Insurance Monopoly Issues: Entry and Efficiencies (April 24); Health Insurance Monopsony: Market Definition (April 24); Health Insurance Monopsony: Competitive Effects (April 25); Health Insurance/Providers: Countervailing Market Power (May 7); Most Favored Nation Clauses (May 7); Financing Design/Consumer Information Issues (June 12); Mandated Benefits (June 25); and Medicare and Medicaid (September 30).[1]

II. INTRODUCTION

In 2002, the Census Bureau estimated that approximately 85 percent of the United States' population had health insurance coverage.[2] Most Americans under the age of 65 obtain health insurance through their employer or a family member's employer. Many obtain coverage through a government program or purchase an individual insurance policy. Medicare covers most Americans aged 65 and over. Many individuals also purchase additional insurance to cover Medicare co-payments and those health care goods and services for which Medicare does not pay.

Health insurance and other third party payment programs pay for a substantial majority of health care services. As Chapter 1 notes, in 2002, national health expenditures were approximately $1.6 trillion. Private health insurance paid for $549.6 billion (35 percent), other private funds paid for $77.5 billion (five percent), and public funds paid for $713.4 billion (46 percent).[3] Consumer out-of-pocket expenses accounted for an additional $212.5 billion in

---

[1] Complete lists of participants on these and other panels are available *infra* Appendix A and in the Agenda, *at* http://www.ftc.gov/ogc /healthcarehearings/completeagenda.pdf.

[2] ROBERT J. MILLS & SHAILESH BHANDARI, U.S. CENSUS BUREAU, HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2002, at 1 (2003), *available at* http://www.census.gov/prod/2003pubs /p60-223.pdf. For more detail on the uninsured, see *infra* Chapter 5, Section VIII.

[3] Stephen Heffler et al., *Health Spending Projections Through 2013*, 2004 HEALTH AFFAIRS (Web Exclusive) W4-79, 83 ex.4, *at* http://content.healthaffairs.org/cgi/reprint/hlthaff.w4.79v1?ck=nck. Consumer contributions to private health insurance premiums are included in the amount for private health insurance expenditures, not in the amount for consumers' out-of-pocket payments. *Id*. at 86.

private expenditures (14 percent).[4]

Health insurance generally covers hospitalization, emergency care, and a range of clinical services. Coverage for pharmaceuticals is more variable, but still fairly common.[5] Hospitalization accounted for only 6.9 percent of consumers' out-of-pocket health-related expenses in 2002, while prescription drugs accounted for 22.9 percent.[6] Prescription drugs are projected to account for 32.5 percent of consumers' out-of-pocket health care expenses by 2013.[7]

Health insurance is subject to extensive federal and state laws and regulations. As noted previously, Americans obtain insurance coverage from various sources, including employment-based insurance, individual insurance, and Federal and State public sources, such as Medicare and Medicaid. These sources provide health care coverage through several types of health plans, including traditional indemnity (or fee-for-service (FFS)) plans, as well as managed care plans, which include health maintenance organizations (HMOs), preferred provider organizations (PPOs), and point of service plans (POSs).

This chapter first summarizes the state and federal laws and regulations that affect the health insurance industry. Next, this chapter describes employment-based, individually-purchased, and government-funded health care coverage, and considers the impact of public purchasing on the overall health care system. This chapter then considers in more detail the PPO. This chapter also discusses some issues concerning the approximately 15 percent of the American population that is without health insurance at some point during the year. Finally, this chapter discusses consumer-driven health care initiatives and proposals.

III. REGULATORY FRAMEWORK

The regulatory framework for health insurance varies, depending on whether coverage is individually-purchased, employment-based, or government-sponsored. The applicable regulatory framework for employment-based health insurance also may vary depending on whether the employer purchases coverage from a commercial insurer, self-insures the health plan, or uses a combination of approaches.

A. McCarran-Ferguson Act

The McCarran-Ferguson Act was adopted in 1945 to resolve a dispute over the authority

---

[4] *Id.* at 83 ex.4.

[5] *Id.* at 80 ex.1.

[6] *Id.* at 87 ex.5.

[7] *Id.*

of state and federal governments to regulate the business of insurance.[8] The McCarran-Ferguson Act clarified that the states had the authority to tax, license, and regulate insurance companies regardless of the insurance company's state of incorporation, as well as the authority to allow insurance companies to engage in cooperative rate-making.[9] Section 2(b) of the McCarran-Ferguson Act specifically reserved authority for Congress to enact laws superceding state insurance laws and regulations, as long as the federal law specifically relates to the business of insurance.[10]

The McCarran-Ferguson Act exempts the "business of insurance" from the antitrust laws to the extent the states regulate such business.[11] Every state has adopted a framework for regulating insurance.[12] Section 3(b) of the McCarran-Ferguson Act provides that "[n]othing contained in this chapter shall render the said Sherman Act inapplicable to any agreement to boycott, coerce, or intimidate, or act of boycott, coercion, or intimidation."[13] Thus, the antitrust laws generally apply to insurance company mergers, monopolization, and other conduct not constituting the "business of insurance," as well as to the specific forms of anticompetitive conduct listed in the McCarran-Ferguson Act.[14] Chapter 6 discusses antitrust enforcement in this

---

[8] McCarran-Ferguson Act, 15 U.S.C. §§ 1012-1014 (1945). The Act was a response to the Supreme Court's decision in United States v. South-Eastern Underwriters Ass'n, 322 U.S. 533 (1944), in which the Supreme Court held that insurance is commerce, and when transacted across state lines, is interstate commerce and subject to federal law, including the antitrust laws. This opinion reversed the Supreme Court's decision in Paul v. Virginia, 75 U.S. 168 (1869) and similar cases, in which the Court had held insurance was not commerce within the meaning of the Commerce Clause and was accordingly not subject to federal regulation. *See South-Eastern Underwriters*, 322 U.S. at 543-45.

[9] McCarran-Ferguson Act § 1012; Group Life & Health Ins. Co. v. Royal Drug Co., 440 U.S. 205, 221, 224 (1979) ("[T]he primary concern of both representatives of the insurance industry and the Congress was that cooperative ratemaking efforts be exempt from the antitrust laws" as long as they were regulated by the state.).

[10] McCarran-Ferguson Act § 1012(b).

[11] *Id.* §§ 1012(b).

[12] *See, e.g.*, NAT'L ASS'N OF INSURANCE COMMISSIONERS (NAIC), ANNUAL REPORT 1 (2003), *at* http://www.naic.org/about/docs/03_annual_ report.pdf.

[13] McCarran-Ferguson Act § 1013(b). *But see* American Chiropractic Ass'n, *Comments Regarding Health Care and Competition Law and Policy (Sept. 9, 2003)* 1 (Public Comment) (arguing certain anticompetitive conduct is protected by the McCarran-Ferguson Act and this puts individual health care providers "at a distinct disadvantage" vis-a-vis insurers).

[14] McCarran-Ferguson Act § 1013. In a trilogy of cases decided between 1978 and 1982, the Supreme Court clarified that the McCarran-Ferguson Act exempted the business of insurance, not the business of insurance companies. The court "identified three criteria relevant in determining whether a particular practice is part of the 'business of insurance' exempted from the antitrust laws by § 2(b): *first*, whether the practice has the effect of transferring or spreading a policyholder's risk; *second*, whether the practice is an integral part of the policy relationship between the insurer and the insured; and *third*, whether the practice is limited to entities within the insurance industry." Union Labor Life Ins. Co. v. Pireno, 458 U.S. 119, 129 (1982). *See also Royal Drug*, 440 U.S. at 221-24, 229-30 n.36 & 37; St. Paul Fire & Marine Ins. Co. v. Barry, 438 U.S. 531, 546, 551 (1978); American Bar

area.

B. State Laws and Regulations

Each state has its own laws and regulations governing health insurance.[15] Although these state rules vary greatly, each state has an insurance commissioner charged with ensuring that insurers are solvent and do not engage in unfair or deceptive practices.[16]

C. ERISA

The Employee Retirement Income Security Act of 1974 (ERISA) broadly preempts state law to establish and preserve uniform and exclusive federal regulation of covered employee benefit plans.[17] ERISA regulates any plan, fund, or program maintained for the purpose of providing retirement benefits, as well as medical or other health benefits for employees or their beneficiaries.[18] ERISA expressly permits states to continue to enforce all state laws that regulate the business of insurance, but it prohibits states from declaring an employee benefit plan that is covered by ERISA to be an insurance company or engaged in the business of insurance.[19] A state law regulates insurance if it is "specifically directed toward entities engaged in insurance" and "substantially affect[s] the risk-pooling arrangement between the insurer and the insured."[20]

Ass'n, Section of Antitrust Law, *Comments Regarding The Federal Trade Commission's Workshop on Health Care and Competition Law and Policy (Oct. 2002)* 7-8 (Public Comment).

[15] *See, e.g.*, KAREN POLLITZ ET AL., GEORGETOWN UNIV. INSTITUTE FOR HEALTH CARE RESEARCH & POLICY, A CONSUMER'S GUIDE TO GETTING AND KEEPING HEALTH INSURANCE IN THE DISTRICT OF COLUMBIA (2002), *available at* http://www.healthinsuranceinfo.net/dc.pdf. This website has consumer guides for all 50 states and the District of Columbia.

[16] NAIC, *supra* note 12, at 1. Many states also have procedures for appealing coverage denials.

[17] Employee Retirement Income Security Act (ERISA) of 1974, 29 U.S.C. § 1001.

[18] *See* James C. Dechene, *Preferred Provider Organizations*, *in* HEALTH CARE CORPORATE LAW: MANAGED CARE § 2.12.7, at 2-50 n.21 (Mark A. Hall & William S. Brewbaker III eds., 1999 & Supp. 1999) ("ERISA requirements include, for example, broad reporting and disclosure requirements (29 U.S.C. §§ 1021 et seq.); participation and vesting requirements (29 U.S.C. §§ 1051 et seq.); funding requirements (29 U.S.C. §§ 1081 et seq.); and fiduciary responsibilities (29 U.S.C. §§ 1101 et seq.).").

[19] 29 U.S.C. § 1144(a), (b)(2)(A), (b)(2)(B). The "savings clause" allows for state regulation of insurance, and the "deemer" clause prevents employee benefit plans from being deemed to be insurers.

[20] Ky. Ass'n of Health Plans, Inc. v. Miller, 538 U.S. 329, 123 S. Ct. 1471, 1479 (2003) (internal citations omitted).

D. HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), which amended ERISA, the Public Health Service Act, and the Internal Revenue Code, establishes minimum federal standards and requirements concerning guaranteed issue and renewability of health coverage, limits exclusions for preexisting medical conditions, provides for credit against maximum preexisting condition exclusion periods for prior health coverage, prohibits individual discrimination based on health factors, and limits disclosure of personal health information.[21] HIPAA applies to both employee benefit plans and state-regulated insurers.[22]

E. COBRA

The Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) provides for continuation of group health coverage that would otherwise be terminated.[23] Former employees and their dependents who lose coverage may temporarily continue their health coverage at group rates if they are willing to pay up to 102 percent of those rates, and they qualify under the terms of the statute. COBRA generally applies to group health plans maintained by employers with 20 or more employees in the prior year. It applies to plans in the private sector and those sponsored by state and local governments.[24]

F. Mandated Benefits

State and federal laws mandate numerous health insurance benefits. Mandated benefits fall into three general categories: (1) *provider mandates*, which require health insurers to cover services provided by certain providers or categories of providers (*e.g.*, any-willing provider laws, freedom of choice, and laws mandating coverage of services provided by a select group of providers (*e.g.*, massage therapists or naturopaths)); (2) *coverage mandates*, which require health insurers to cover particular classes of individual patients and conditions (*e.g.*, mental health parity); and (3) *benefit mandates,* which require health insurers to provide a specified minimum

---

[21] Health Insurance Portability and Accountability Act (HIPAA) of 1996, Pub. L. No. 104-191, 110 Stat. 1936. *See also* U.S. Dept. of Labor, *Fact Sheet: HIPAA*, *at* http://www.dol.gov/ebsa/newsroom/fshipaa.html (last visited June 23, 2004); U.S. Dep't of Labor, *Frequently Asked Questions About Portability of Health Coverage and HIPAA*, *at* http://www.dol.gov/ebsa/faqs/faq_consumer_hipaa.html (last visited June 23, 2004). HIPAA also contains a number of provisions relating to fraud and abuse enforcement, which are not addressed in this Report.

[22] *See supra* note 21. *See also* 29 U.S.C. §§ 1181-1183 (ERISA); 42 U.S.C. §§ 300gg *et seq*. (Public Health Service Act).

[23] The Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986, Pub. L. No. 99-509, 100 Stat. 1874. *See also* PENSION & WELFARE BENEFITS ADMIN., U.S. DEPT OF LABOR, HEALTH BENEFITS UNDER THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (2001), *at* http://www.labor.gov/ebsa/pdf/cobra99.pdf.

[24] PENSION & WELFARE BENEFITS ADMIN., *supra* note 23, at 1-2.

level of benefits (*e.g.*, 48 hour post-partum hospitalization, direct access to specialists).[25] Some states rarely mandate benefits, while other states do so routinely.[26] Federal law mandates a few benefits.[27]

G. Federal Tax Code

The tax code subsidizes employment-based health insurance. Employer contributions for employees' health insurance coverage are deductible to employers, but are not considered taxable income to employees.[28] Thus, employees obtain health care coverage through their employer with pre-tax dollars, which results in a tax subsidy for employment-based health insurance of more than $100 billion per year.[29]

IV. EMPLOYMENT-BASED COVERAGE

The number of people with employment-based insurance fluctuated during the 1990s, but

---

[25] Although there are three categories of mandated benefits, this Report focuses primarily on "provider mandates." *See infra* Chapter 6.

[26] Gitterman 6/25 at 8-9 (noting that Idaho has only ten mandated benefits, but Maryland has 52).

[27] The federal Newborns' and Mothers' Health Protection Act requires group health plans and insurers that provide benefits for hospital lengths of stay in connection with childbirth to provide coverage for a 48-hour hospital stay following a normal delivery and a 96-hour hospital stay following a cesarean delivery. The Mental Health Parity Act generally requires group health plans and insurers to provide for parity in lifetime and annual dollar limits on mental health benefits with dollar limits on medical and surgical benefits. The Women's Health and Cancer Rights Act requires plans and insurers to provide coverage for post-mastectomy benefits, including benefits for all stages of reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction to produce a symmetrical appearance, prostheses and treatment of physical complications of the mastectomy, including lymphademas. *See infra* Chapter 6.

[28] David A. Hyman & Mark Hall, *Two Cheers for Employment-Based Health Insurance*, 2 YALE J. HEALTH POL'Y L. & ETHICS 23, 25 (2001).

[29] *Id.* (noting that exclusion from income in a progressive tax system means that subsidy varies with income, with greater subsidies going to those with higher incomes). *See also* OFFICE OF MGMT. & BUDGET, BUDGET OF THE U.S. GOVERNMENT: ANALYTICAL PERSPECTIVES, FISCAL YEAR 2004 (2003) (estimating personal income tax expenditure for health care at $130.2 billion), *available at* http://www.whitehouse.gov/omb/budget/fy2004/pdf/spec.pdf; John Sheils & Randall Haught, *The Cost of Tax-Exempt Health Benefits In 2004*, 2004 HEALTH AFFAIRS (Web Exclusive) W4-106, 110 (estimating personal income tax expenditure for health care at $122.1 billion), *at* http://content.healthaffairs.org/cgi/reprint/hlthaff.w4.106v1.pdf. *See also* Stuart Butler, *A New Policy Framework for Health Care Markets*, 23 HEALTH AFFAIRS 22, 23 (Mar./Apr. 2004) (suggested that families receive more than $140 billion in federal and state tax relief "if they hand over the control of health insurance to their employers."). One panelist also noted the "huge distortions created by the tax system." Francis 9/30 at 129.

is currently stabilized at approximately 61 percent of the population.[30] The significance of employment-based health insurance varies by industry. In some sectors of the economy (*e.g.*, construction, service industries, and retail), employment-based health insurance is less common than in other sectors of the economy (*e.g.*, finance and manufacturing).[31] Employer size matters as well; the larger the firm, the more likely it is that employees will be offered employment-based health insurance.[32] Not all employees take advantage of employment-based health insurance, and some employees obtain coverage for themselves, but not for their beneficiaries.[33] Although it is common parlance to speak of "employer contributions" to the cost of health care coverage, employees ultimately bear these costs, in the form of lower salaries and fringe benefits.[34]

A. Sources and Regulation of Employment-Based Coverage

Employers offer health coverage to their employees through various sources, including commercial insurance companies, employers' self-insured plans, and various combinations of the two.[35] The applicability of federal and state laws and regulations varies, depending on the source of health care coverage an employer makes available to employees.

Employers who offer health insurance through commercial insurers usually negotiate on behalf of their employees for specific benefits at a specified monthly premium per person or

---

[30] *See* MILLS & BHANDARI, *supra* note 2, at 1; John Holahan & Marie Wang, *Changes In Health Insurance Coverage: 1994-2000*, 2002 HEALTH AFFAIRS (Web Exclusive) W162, 163, *at* http://content.healthaffairs.org/cgi/content/full/hlthaff.w2.162v1/DC1. *See also* Hyman & Hall, *supra* note 28, at 26 (stating that approximately 177 million Americans obtain health insurance coverage through their employers); INSTITUTE OF MEDICINE (IOM), COVERAGE MATTERS: INSURANCE AND HEALTH CARE 8 (2001) (noting that in 2000, approximately 66 percent of the population under age 65 receive employment-based health care insurance; most Americans older than 65 years of age receive health care coverage under the Medicare program).

[31] John Holahan & Marie Wang, *Changes In Health Insurance Coverage During The Economic Downturn: 2000-2002*, 2004 HEALTH AFFAIRS (Web Exclusive) W4-31, 40, *at* http://content.healthaffairs .org/cgi/reprint/hlthaff.w4.31v1?ck=nck.

[32] MILLS & BHANDARI, *supra* note 2, at 7-8 & fig.3; Holahan & Wang, *supra* note 31, at 39-40 ex.8.

[33] Hyman & Hall, *supra* note 28, at 26.

[34] *See* Darling 6/12 at 100-102 ("[A]ll [health] benefits are foregone wages or other benefits paid for by the worker"); Jonathan Gruber, *Health Insurance and the Labor Market*, *in* 1A HANDBOOK OF HEALTH ECONOMICS 645, 699 (Anthony J. Culyer & Joseph P. Newhouse eds., 2000) ("[I]ncreases in health insurance costs appear to be fully reflected in worker wages … .").

[35] *See* Am. Med. Sec. v. Bartlett, 915 F. Supp. 740, 742 (D. Md. 1996), *aff'd*, 111 F.3d 358 (4th Cir. 1997). *See also* S. Allen 4/25 at 105-06 (in Arkansas, commercial insurance products are provided by three national plans, two large local plans, and 64 in-state and out-of state third party administrators, as well as self-insured plans providing health coverage to 45 to 50 percent of the covered population).

family.[36] Historically, most employers paid a percentage of the employees' monthly premium, but some employers are now shifting to a fixed dollar contribution in an effort to contain costs.[37] Commercially insured plans are generally subject to state laws and regulations, and federal law.[38]

Some employers choose to self-insure their employees' health insurance plans by assuming 100 percent of the risk.[39] If the employer fully self-insures the health benefit plan, then it falls within the scope of ERISA and the state cannot regulate it.[40] The larger the firm, the more likely it is self-insured.[41]

Some employers create self-insured plans, but contract with commercial insurance companies to act as a third-party administrator (TPA) for claims processing, or for access to a provider network. ERISA preemption of state law varies, depending on the contractual relationship between the self-insured plan and the commercial insurer.[42]

Some employers self-insure their health plan up to a certain amount and purchase an insurance policy to cover costs that exceed that pre-determined, agreed upon amount.[43] This is

---

[36] Commercial insurance companies include both for-profit and not-for-profit entities. For-profit companies include, among others, Aetna, Cigna, and UnitedHealthCare. Although Blue Cross and Blue Shield Plans traditionally have been nonprofit companies, some have converted, or attempted to convert, to for-profit status in recent years. *See, e.g.*, S. Allen 4/25 at 105-06; Ginsburg 4/23 at 19.

[37] *See* Alain Enthoven, *Employment-Based Health Insurance is Failing: Now What?*, 2003 HEALTH AFFAIRS (Web Exclusive) W3-237, 242-43 (stating that paying a fixed percentage of employees' premiums rewards those that choose the most expensive plan), *at* http://content.healthaffairs.org/cgi /reprint/hlthaff.w3.237v1.pdf.

According to one report, employee contributions in 1996 accounted for approximately 30 percent of total health insurance premiums. Robert Kuttner, *The American Health Care System: Employer-Sponsored Health Coverage*, 340 NEW ENG. J. MED. 248, 250 (1999).

[38] For example, the Public Health Service Act (PHSA) and ERISA, as amended by HIPAA, impose certain federal requirements on insurers. *See supra* notes 21-22 and accompanying text. Employer-sponsored plans must also comply with ERISA, even if they are fully insured.

[39] *Am. Med. Sec.*, 915 F. Supp. at 742, 746.

[40] *See* Metro. Life Ins. Co. v. Massachusetts, 471 U.S. 724 (1985); *Am. Med. Sec.*, 915 F. Supp. at 742. *See also* Greg Kelly, *Financing Design / Consumer Information Issues* 2 (6/12) [hereinafter G. Kelly (stmt)], *at* http://www.ftc.gov/ogc/healthcarehearings/docs/030611gregkelly.pdf; G. Kelly 6/12 at 114.

[41] *See, e.g.*, Gingrich 6/12 at 15-16; Holahan & Wang, *supra* note 31, at 40; NEWT GINGRICH ET AL., SAVING LIVES & SAVING MONEY 84 (2003).

[42] *See generally* Dechene, *supra* note 18, § 2.12.7, at 2-52.

[43] *Am. Med. Sec.*, 915 F. Supp. at 742. The agreed upon amount is called the "attachment" point. There are two types of attachment points – specific (or individual) and aggregate. The specific attachment point is the amount above which the insurer must reimburse the employer for eligible claims made by an *individual* plan participant. The aggregate attachment point is the amount above which the insurer must reimburse the employer for

often called "stop-loss" coverage.[44] For example, an employer may choose to self-insure its employees' aggregate health care expenditures up to a maximum of $1 million per year, and contract with a traditional insurance company to cover any health care costs in excess of that $1 million. ERISA generally preempts state laws that apply to self-insured plans, including plans that purchase such stop loss insurance coverage.[45] In *American Medical Security v. Bartlett*, the Fourth Circuit held that ERISA preempted a state regulation that was designed to subject to the state's insurance laws self-insured plans carrying stop-loss insurance below state-specified minimum levels.[46]

Most cases have held "that ERISA preempts application of state insurance laws to self-insured plans that have arrangements with TPAs" to provide administration and claims processing services.[47] The case law is mixed whether ERISA preempts state laws if a self-insured plan contracts with an insurer to provide access to a provider network. For example, some courts have held that a state's any willing provider laws will apply to PPOs established by an insurance company, even if the insurer is developing the PPO for use by an ERISA plan.[48] Others have held such laws are preempted by ERISA.[49] The Supreme Court's recent decision in

---

eligible claims made by *all* plan participants. *Id*. at 742.

[44] *Id.* at 742.

[45] *See Am. Med. Sec.*, 111 F.3d at 362. *See also* Metro. Life Ins. Co. v. Massachusetts, 471 U.S. 724 (1985); Dechene, *supra* note 18, § 2.12.7, at 2-52 n.29. The Supreme Court considered the boundaries of ERISA preemption in four recent cases: *Aetna Health Inc. v. Davila*, 124 S. Ct. 2488 (2004); *Kentucky Ass'n of Health Plans, Inc. v. Miller*, 538 U.S. 329 (2003); *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355 (2002); *Pegram v. Herdrich*, 530 U.S. 211 (2000).

[46] *Am. Med. Sec.*, 111 F.3d at 362 (state regulation was designed to force self-insured plans to provide state mandated benefits if the employer was reimbursed for employees' eligible claims below $10,000 per beneficiary).

[47] Dechene, *supra* note 18, § 2.12.7, at 2-51 to 2-52 n.28 (citing to *Children's Hosp. v. Whitcomb*, 778 F.2d 239 (5th Cir. 1985), *Moore v. Provident Life & Accident Ins. Co.*, 786 F.2d 922 (9th Cir. 1986), *Ins. Bd. of Bethlehem Steel Corp. v. Muir*, 819 F.2d 408 (3rd Cir. 1987), *State Farm Mut. Auto. Ins. Co. v. C.A. Muer Corp.*, 397 N.W.2d 299 (Mich. Ct. App. 1986)).

[48] *See, e.g.*, Stuart Circle Hosp. Corp. v. Aetna Health Mgmt., 995 F.2d 500 (4th Cir. 1993); Blue Cross & Blue Shield v. St. Mary's Hosp., Inc., 426 S.E.2d 117 (Va. 1993).

[49] *See, e.g.*, BPS Clinical Lab. v. Blue Cross & Blue Shield, 522 N.W.2d 902 (Mich. Ct. App. 1994). The Supreme Court held that ERISA does not preempt a New York state law that required hospitals to impose varying surcharges on health insurers, including self-insured ERISA plans. N.Y. State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645 (1995). The Supreme Court did note, however, that a state law that attempted to force ERISA plans to adopt certain benefits might be preempted. *Id.* at 668. The case does not clarify whether state laws governing TPAs or PPOs are preempted when contracting with ERISA plans. *See* Dechene, *supra* note 18, § 2.12.7, at 2-54 to 2-55.

Kentucky Ass'n of Health Plans, Inc. v. Miller does not settle this area of the law.[50]

B. Issues and Priorities

One speaker provided an overview of the priorities of employees and employers in dealing with health insurance coverage.[51] Employees want good coverage at a reasonable price that is administratively simple, covers alternative treatments, and continues into retirement.[52] Employees also are concerned about costs.[53] A 2002 study reported that 43 percent of employees feared that their employment-based coverage would be cut back within the next year, 21 percent feared they would not be able to afford the increases in out-of-pocket expenses, and 8 percent feared they would lose their employment-based benefits within one year.[54] From an employee perspective, if premium increases are larger than salary increases, take-home pay declines.[55]

Surveys reveal that choice is important to many employees, but employers vary greatly in the number of insurance plan options they offer their employees.[56] The larger the employer, the more likely there will be more than one coverage option, but the health plan options can change

---

[50] Kentucky Ass'n of Health Plans, Inc. v. Miller, 538 U.S. 329, 123 S. Ct. 1471, 1476 n.1 (2003) (noting that Kentucky's law was specifically limited to "employee benefit plans 'not exempt from state regulation by ERISA.'"). For a discussion of any willing provider laws see *infra* Chapter 6.

[51] *See* M. Young 6/12 at 91-96; Michael Young, *Financing Design/Consumer Information Issues* 2-3, 7 (6/12) (slides) [hereinafter M. Young Presentation], *at* http://www.ftc.gov/ogc /healthcarehearings/docs/030612young.pdf.

[52] M. Young 6/12 at 91-94. The same panelist noted that although some administrative hassles have been eliminated as electronic claims processing becomes more prevalent, electronic databases are not universal and many employees still face administrative difficulties as they navigate the health care system. *Id.* at 93. Many insurance companies, on which employers rely to set the standards concerning what treatments are covered, also are slow to adopt coverage for alternative treatments. Finally, he noted that the percentage of large employers providing health benefits for retirees appears to be dwindling quickly. *Id.* at 93-94. *See also* THE KAISER FAMILY FOUND., EMPLOYER HEALTH BENEFITS 2003 ANNUAL SURVEY § 11, at 132 (in 2003, 38 percent of large employers (200 or more employees) offered health benefits to retirees versus 66 percent in 1988; since 1991, the range has fluctuated from a high of 46 percent in 1991 to a low of 35 percent in 2000; in 2003, 10 percent of small employers (less than 200 employees) offered such benefits), *available at* http://www.kff.org/insurance/ehbs2003-abstract.cfm.

[53] M. Young 6/12 at 92.

[54] M. Young 6/12 at 94-95; M. Young Presentation, *supra* note 51, at 3 (citing a "Robert Wood Johnson Foundation survey of 800 registered voters, January 2002").

[55] *See, e.g.*, M. Young 6/12 at 92 ("[A] lot of our clients will have employees whose payroll deduction for health care will be greater than their increase in their salary. And what happens is their take-home pay becomes less"). Darling 6/12 at 101 ("[A]ll [health] benefits are foregone wages or other benefits paid for by the worker").

[56] *See, e.g.*, M. Young 6/12 at 91, 95; KAISER FAMILY FOUND., *supra* note 52, § 4, at 62 (in 2003, 62 percent of covered workers had more than one health plan option, and this percent has been relatively stable since 1996).

from year-to-year.[57]

According to several panelists, employers are questioning whether they should be providing health insurance coverage.[58] One speaker cautioned that employers cannot maintain the health care financing structure the way it is and, without changes, many employers will be forced to take more drastic measures with respect to providing employment-based health care coverage.[59] Another speaker suggested that employers were likely to continue providing health coverage, but the amount of money they contribute will not keep pace with the cost of health care.[60] Some panelists asserted that small employers face greater challenges than large employers.[61]

Some commentators criticize employment-based insurance coverage because it reflects the coverage preferences of employers instead of employees.[62] Others argue that the existence of employment-based health insurance impedes achieving universal coverage.[63] Some panelists suggest that the regulatory environment favors large employers over small employers and those that purchase individual policies.[64]

Despite these employee and employer misgivings, as well as commentator criticisms, one

---

[57] M. Young 6/12 at 91-92; M. Young Presentation, *supra* note 51, at 2. *See also* KAISER FAMILY FOUND., *supra* note 52, § 4, at 64 (38 percent of covered workers have just one plan option; 74 percent of large employers offered employees a choice between at least two health plans versus 26 percent of small employers (less than 200 employees) that offered a choice).

[58] Darling 6/12 at 107; M. Young 6/12 at 99.

[59] M. Young 6/12 at 99; M. Young Presentation, *supra* note 51, at 7 (structure of employment-based health insurance has changed in recent years: less tightly managed HMOs, more cost sharing with employees, more choices of plans; more drastic changes possible in future: consideration of dropping coverage, consideration of consumer-driven health plans).

[60] Darling 6/12 at 107 ("[T]he amount of money they [employers] pay will grow more slowly than the cost of health care will, and therefore the employees and their retirees will be spending a lot more money").

[61] *See, e.g.*, M. Young 6/12 at 95-96; Gingrich 6/12 at 15-16.

[62] *See, e.g.*, EMPOWERING HEALTH CARE CONSUMERS THROUGH TAX REFORM (Grace-Marie Arnett ed., 1999); Butler, *supra* note 29, at 23; Stuart Butler & David B. Kendall, *Expanding Access and Choice for Health Care Consumers Through Tax Reform*, 18 HEALTH AFFAIRS 45, 46 (Nov./Dec. 1999); SHARON SILOW-CARROLL ET AL., IN SICKNESS AND IN HEALTH? THE MARRIAGE BETWEEN EMPLOYERS AND HEALTH CARE (1995); Uwe E. Reinhardt, *Employer-Based Health Insurance: A Balance Sheet*, 18 HEALTH AFFAIRS 124, 127 (Nov./Dec. 1999). *See also* Hyman & Hall, *supra* note 28, at 26-27 ("[D]ifficulties with employment-based insurance stem from the fact that someone other than the ultimate consumer of health care is making most of the decisions about what coverage to purchase and how much to pay"); M. Young Presentation, *supra* note 51, at 4.

[63] *See, e.g.*, SILOW-CARROLL ET AL., *supra* note 62; Reinhardt, *supra* note 62, at 127.

[64] M. Young 6/12 at 95-96; G. Kelly 6/12 at 114-16; Gingrich 6/12 at 15-16.

benefits consultant stated that there is a continuing role for employment-based coverage.[65] He noted that employers can devote greater resources to understanding the various insurance product offerings and can represent a larger purchasing group than individual employees. Employers generally have greater negotiating power with insurance companies than individuals.[66] Group underwriting spreads the risks and provides lower administrative costs.[67] Moreover, group policies generally provide more benefits, such as prescription drug coverage.[68] Others note that employment-based insurance coverage provides a stable and effective source of coverage that is valued by employees.[69]

One panelist argued that the tax preference for employment-based health insurance should be eliminated.[70] He suggested that an individual-based health insurance system would be more conducive to quality and price competition.[71] He explained that between 12 and 16 percent of the U.S. workforce changes jobs each year, and as a result, employers have little incentive to offer health insurance plans that invest in quality health care up-front because they may be more costly in the short-run.[72] He concluded that a system that enables individuals to purchase a portable health insurance plan, which they may keep for decades, will foster development of a market-based health care sector, including health plans that focus on quality of care and health for the long-term.[73]

Several commentators also have suggested eliminating the tax bias in favor of

---

[65] M. Young 6/12 at 99; Darling 6/12 at 107. *But see* Gingrich 6/12 at 15. In fact, the tax preferences for employment-based coverage likely confers the most significant advantage. *See* Hyman & Hall, *supra* note 28, at 25

[66] *See* M. Young 6/12 at 98; M. Young Presentation, *supra* note 51, at 5. *But see* Gingrich 6/12 at 15 ("[W]e artificially constrain and raise the cost of insurance for the self-employed, the unemployed, small businesses, and family farms. There is no inherent reason we can't have a nationwide market based on something like eBay, where people can go online with very little intermediation cost and buy into a national risk pool …. You should individually be able to buy group insurance.").

[67] M. Young 6/12 at 98; M. Young Presentation, *supra* note 51, at 10.

[68] M. Young Presentation, *supra* note 51, at 10.

[69] *See* Darling 6/12 at 100 (referencing employee surveys). This panelist emphasized the importance employees place on health benefits, stating that some large employers suspended their contributions to employees' 401(k) plans, but were very modest with decreases in health benefits. She noted that employees went on strike against Hershey Corporation over an increase from 3 percent to 5 percent in employees' contributions to health coverage. *Id.* at 101-102. *See also* Hyman & Hall, *supra* note 28, at 42-43.

[70] *See* Greenberg 6/12 at 63.

[71] *Id.* at 64.

[72] *Id.* at 64-65 (the investment up-front would render the plans less-costly in the long-run).

[73] *Id.* at 64-69. *See also infra* notes 200-209, and accompanying text (discussing consumer-driven health care), and *supra* Chapter 1 (discussing quality).

employment-based health insurance.[74] One commentator stated that as consumers begin making their own decisions about health insurance and care, market forces will encourage the private sector to create more information resources to enable consumers to make more informed choices.[75] Another commentator stated that market forces in health care "are badly distorted or blocked by employers' failure to offer employees responsible choices; by the tax treatment of 'employer-paid' health insurance; by providers' resistance to the collection and publication of quality-related information; by provider monopolies; and by laws and regulations that block the development of high-quality, cost-effective alternatives to fee-for-service (FFS) indemnity insurance."[76] He suggested that these problems are not insurmountable and that market forces could be strengthened by a number of steps, including providing consumers with information, economic incentives, and the ability to choose among health plans.[77]

One speaker described his company's actions to address rising health care costs and to make employees more cost-conscious. In 2003, the company provided a fixed subsidy of $220 per month to employees for health care coverage, regardless of the health care plan they chose. His company also increased copayments for office and emergency room visits, introduced hospital deductibles, and carved out the pharmacy benefit and introduced a three-tier formulary.[78] This panelist explained that given his company's "defined contribution strategy, [the] employees are well aware of the accelerating cost of health care. Their response has been to move to lower cost plans, even if it means more hassles to access specialists."[79]

---

[74] Butler, *supra* note 29, at 23 (suggesting government "expand tax credits and other tax relief for non-employer-sponsored coverage and for consumers' direct expenditures, preferably in combination with a phased-in ceiling on the tax exclusion"); Scott Harrington & Tom Miller, *Perspective: Competitive Markets for Individual Health Insurance*, 2002 HEALTH AFFAIRS (Web Exclusive) W359, 360 (suggesting more comparable tax treatment for all health insurance consumers), *at* http://content.healthaffairs.org/cgi/reprint/hlthaff.w2.359v1.pdf. *See also* Gingrich 6/12 at 6-21.

[75] Butler, *supra* note 29, at 23-24. *See infra* notes 200-209, and accompanying text, for a discussion of consumer-driven health care.

[76] Alain Enthoven, *Market Forces And Efficient Health Care Systems*, 23 HEALTH AFFAIRS 25, 25 (Mar./Apr. 2004) (stating that market forces in this context "meet certain fundamental conditions, including that the buyers are (reasonably well) informed, are using their own money (at least at the margin), and face a choice among competing alternative suppliers").

[77] *Id.* at 25-26 (suggesting that a fixed dollar amount, rather than a fixed percentage of the premium, as well as allowing employees to share in the savings if they choose a lower-cost health plan, is one way to provide incentives for employees to seek greater value for their money). *See also* Enthoven, *supra* note 37, at 242-43; Kelly Hunt et al., *Paying More Twice: When Employers Subsidize Higher-Cost Health Plans*, 16 HEALTH AFFAIRS 150, 154 (Nov./Dec. 1997) (research findings, although not definitive, suggested that between 1994-1995, "firms that did not subsidize more expensive health plans had lower price increases or greater price decreases than those that did subsidize").

[78] Meyer 4/11 at 24-27. *See also infra* Chapter 7.

[79] Meyer 4/11 at 27-28.

One panelist argued that state and federal regulations have undermined the performance of the health insurance market.[80] According to this panelist, HIPAA and follow-on state regulations requiring guaranteed issue and limiting the prices that can be charged in the small-group insurance market have had disastrous consequences.[81] Guaranteed issue requires insurers that sell coverage to employers in the small group market to offer and sell that coverage to all small employers in the market. This panelist suggested that with guaranteed issue, a small employer may choose to remain uninsured until one of its employees needs extensive medical care, knowing that regulations require the insurance companies to issue coverage and some state laws restrict the price and type of coverage.[82] This panelist stated that such regulation causes "healthier groups to leave the market, prices to skyrocket, and insurers to stop offering coverage."[83] Another panelist identified a number of regulations that restrict competition – sometimes by design, and other times unintentionally.[84]

V. INDIVIDUAL INSURANCE

In 1999, approximately 16 million working-age adults and children – almost seven percent of the population under the age of 65 – obtained health insurance coverage through individually issued, non-group policies.[85] One set of commentators suggest the small market share for individual health insurance is due, at least in part, to the tax-subsidies provided for employment-based coverage.[86] Individual insurance policies generally are more expensive than group policies because there is no spreading of underwriting risk, and adverse selection and

---

[80] *See* G. Kelly 6/12 at 118; G. Kelly (stmt), *supra* note 40, at 3, 5-6.

[81] *See* G. Kelly 6/12 at 115-16; G. Kelly (stmt), *supra* note 40, at 3.

[82] G. Kelly 6/12 at 115-18 ("Under [state] guaranteed issue, an individual who becomes ill may apply for private insurance coverage and must be accepted. This is comparable to allowing a person to purchase auto insurance for a car wreck after its happened."); G. Kelly (stmt), *supra* note 40, at 5-6.

[83] G. Kelly 6/12 at 118; G. Kelly (stmt), *supra* note 40, at 5-6. This speaker indicated that guaranteed issue resulted in a minimum monthly premium for family coverage of $1,176 in Portland, Maine, $3,576 in Trenton, New Jersey, and $1,113 in Ithaca, New York. Conversely, in three states without such laws, the monthly premium for comparable family coverage was $355 in Madison, Wisconsin, $410 in Arlington, Virginia, and $461 in Pittsburgh, Pennsylvania. G. Kelly 6/12 at 116-17; G. Kelly (stmt), *supra* note 40, at 4.

[84] Francis 9/30 at 129-30.

[85] IOM, *supra* note 30, at 41.

[86] *See* Harrington & Miller, *supra* note 74, at 360 (suggesting "[b]roader access to more comparable tax treatment for all health insurance consumers, regardless of where or how they purchase insurance, is needed to provide a deeper, more diversified pool of potential customers and move the individual market beyond a narrow niche role.").

marketing and administrative expenses are greater than with group policies.[87] Nonetheless, according to two panelists, regulation has altered this situation in some states, making small group coverage more expensive than individual insurance.[88] Consumers can obtain guidance about purchasing individual policies from various sources, including insurers, government, industry associations, and independent groups.[89]

VI. PUBLICLY-FUNDED PROGRAMS

Medicare and Medicaid pay for approximately $500 billion in health care expenses each year. Medicare provides coverage for approximately 40 million elderly and disabled Americans, and Medicaid provides coverage for approximately 50 million low-income Americans.[90] Although the programs are not directly subject to the antitrust or consumer protection laws enforced by the Agencies, one panelist observed that these programs "are dominant realities of the American health care system. They influence the nature of competition. They influence the areas in which competition can exist, and the rules under which it has to exist, and the risks and rewards, and the institutional framework within which all of those things take place."[91] This section focuses on two key government-funded programs: Medicare and Medicaid.

---

[87] *See* GREG SCANDLEN, DEFINED CONTRIBUTION HEALTH INSURANCE 17 (Nat'l Center for Policy Analysis, Policy Backgrounder No. 154, 2000) (stating that expenses are higher because insurance companies use agents to screen individuals for the highest risks, "people in the individual market are older, sicker and poorer than those in the group market … [and that] they are also unsubsidized by either their employers or by the government … [and] lapse rates are high as people acquire coverage when they have the money, and drop it when they run out of funds"). *See also* G. Kelly (stmt), *supra* note 40, at 5; Gingrich 6/12 at 15; Harrington & Miller, *supra* note 74, at 359.

[88] *See* G. Kelly 6/12 at 115-16; G. Kelly (stmt), *supra* note 40, at 7 (noting that "the small group market is, on average, much more expensive than the individual market" and small business members paid approximately 25 percent more than individuals for insurance policies available on the Internet); M. Young Presentation, *supra* note 51, at 10; M. Young 6/12 at 92. Individual policies, however, often do not provide coverage as comprehensive as that available in the group market, and such pricing comparisons may not be based on similar coverage. *See also* SCANDLEN, *supra* note 87, at 17 (HIPAA requirements and other cost-increasing regulations more prevalent in the small group market).

[89] *See, e.g.*, KAREN POLLITZ ET AL., *supra* note 15, at 12; Agency for Healthcare Research & Quality (AHRQ), *Pub. No. 93-0018* , *Checkup on Health Insurance Choices* (Dec. 1992), *at* http://www.ahrq.gov/consumer/insuranc.htm (last visited June 28, 2004); American Health Insurance Plans (AHIP), *Guide to Health Insurance*, *at* http://www.ahip.org/content/default.aspx?bc=41|329|351 (last visited June 28, 2004).

[90] *See, e.g.*, Antos 9/30 at 114 (there is some overlap of coverage for the two programs, resulting in approximately 80 million people being covered by these two programs); Joseph Antos, *Can Medicare and Medicaid Promote More Efficient Health Care?* 1 (9/30), *at* http://www.ftc.gov/ogc/healthcarehearings /docs/030930josephantos.pdf.

[91] Hyman 9/30 at 112-13.

A. Medicare

In 1965 the Medicare Program was created.[92] Medicare initially provided certain health care coverage to eligible individuals age 65 or older, but was expanded in 1972 to cover individuals under age 65 with End-Stage Renal Disease (ESRD) and some other disabilities.[93] Most individuals who are eligible for either Social Security Old-Age Benefits or Railroad Retirement Benefits also are eligible for Medicare.[94]

Medicare has multiple parts. Part A provides hospital insurance coverage. Most people are eligible for Medicare Part A because they or a spouse paid into the program through payroll tax deductions while they were employed.[95] Part A helps pay for inpatient hospital stays, skilled nursing facility care, some home health care, hospice care, and blood provided while in a hospital or skilled nursing care facility.[96]

Medicare Part B is optional supplementary medical insurance, covering, among other things, doctors' visits, outpatient medical and surgical services and supplies, diagnostic tests, and durable medical equipment (*e.g.*, wheelchairs, hospital beds, and oxygen). Individuals must pay a premium – $66.60 per month in 2004 – to participate in Part B.[97] Premiums cover

---

[92] 42 U.S.C. § 1395 *et. seq*. *See also* Centers for Medicare & Medicaid Services (CMS), *Medicare Information Resource*, *at* http://www.cms.hhs.gov/medicare (last modified Sept. 12, 2003).

[93] ESRD is chronic, irreversible kidney disease. Patients with ESRD require dialysis, usually 3 times per week, to cleanse the blood of toxins, which, if not removed through dialysis, will kill the patient. There are approximately 400,000 people in the U.S. with ESRD, of whom 300,000 must receive dialysis every other day. Cashia 9/30 at 164; Joseph Cashia, *National Renal Alliance: Success Starts with Choosing the Right Partner* 9 (9/30) (slides), *at* http://www.ftc.gov/ogc/healthcarehearings/docs/030930cashia.pdf. Medicare pays for over 70 percent of all dialysis treatments. One speaker testified about several problems with the Medicare ESRD program: Medicare pays dialysis treatment centers only 30 percent of what it paid in 1984 (after accounting for inflation); there is inconsistent state regulatory oversight and credentialing; and there are payment differentials between urban and rural treatment centers. Cashia 9/30 at 167, 169-172.

[94] 42 U.S.C. § 1395 *et. seq*.

[95] 42 U.S.C. § 1395c. *See also* U.S. DEP'T OF HEALTH & HUMAN SERVICES (HHS), MEDICARE & YOU: 2004 (2004), *available at* http://www.medicare.gov/publications/pubs/pdf/10050.pdf. Because Medicare is financed on a "pay-as-you-go" basis, the expenses of current beneficiaries are paid with contributions from payroll taxes imposed on those currently working. Individuals who did not pay into Medicare through payroll taxes can participate in Part A by paying a premium.

[96] HHS, *supra* note 95.

[97] *See Id.* The premium can be changed annually. The monthly premium is usually taken out of the recipient's monthly Social Security, Railroad Retirement, or Office of Personnel Management Retirement payment. Other covered services include: ambulatory surgery center facility fees for approved procedures, part-time or intermittent home health care services, certain outpatient medical and mental health therapies, and blood provided as an outpatient or as part of a Part B covered service.

approximately 25 percent of the expenditures for Part B services.[98]

Medicare does not pay for all hospital or other medical expenses.[99] Many Medicare beneficiaries also purchase private Medicare Supplemental Insurance Policies known as Medigap policies.[100] Medigap policies are federally regulated and must use one of ten standardized policies. Some of these standardized Medigap policies also pay for some routine services and prescription drugs.[101]

In 1997, Congress enacted Medicare + Choice (M+C) as Part C of Medicare. M+C was renamed Medicare Advantage (MA) pursuant to the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA).[102] MA allows Medicare beneficiaries to join privately operated managed care plans.[103] The plans are paid an administratively determined rate by Medicare and plans also may charge an additional premium and offer additional benefits.[104] Medicare beneficiaries who joined MA plans often received greater benefits (*e.g.*, prescription drug coverage) in exchange for accepting limits on their choice of providers.[105] In 2002, MA plans were providing health care to 5 million Medicare beneficiaries, down from 6.35 million

---

[98] The remaining 75 percent comes from general revenues.

[99] For example, in 2003, Medicare beneficiaries were responsible for the following costs of hospital and medical care: (1) hospital stays – $840 per day for the first 60 days, $210 per day for days 61-90, and $420 per day for days 91-150; (2) skilled nursing facilities – up to $105 per day for days 21-100; (3) blood – cost of the first three pints; (4) Medicare Part B yearly deductible – $100 per year; and (5) Coinsurance and copayments – 20 percent of Medicare-approved amount for most covered services, 50 percent of Medicare-approved amount for outpatient mental health treatment, and copayments for outpatient hospital services. *See generally*, U.S. DEP'T OF HEALTH & HUMAN SERVICES (HHS), CHOOSING A MEDIGAP POLICY: A GUIDE TO HEALTH INSURANCE FOR PEOPLE WITH MEDICARE, *at* http://www.medicare.gov/Publications /Pubs/pdf/02110.pdf.

[100] *See* HHS, *supra* note 95, § 8, at 63-68 (entitled "Other Insurance and Ways to Pay Health Care Costs"). Some Medicare beneficiaries receive additional health insurance through employer provided retirement programs. By statute, Medicare is a secondary payor to such benefits. *See generally*, KAISER FAMILY FOUND., *supra* note 52.

[101] *See* HHS, *supra* note 99.

[102] Pub. L. No. 108-173, 117 Stat. 2066 (2003). Pursuant to Implementation of Medicare Advantage Program, 42 U.S.C. § 1395w-21, any legislative reference to Medicare + Choice is deemed a reference to Medicare Advantage and MA.

[103] *See* HHS, *supra* note 95, § 6, at 43-54 (entitled "Medicare + Choice Plans").

[104] Pizer 4/23at 146-47; Steven Pizer, *Competition in the Medicare+Choice Program* 5 (4/23) (slides) [hereinafter Pizer Presentation], *at* http://www.ftc.gov/ogc/healthcarehearings/docs/pizer.pdf; Steven Pizer & Austin Frakt, *Payment Policy and Competition in the Medicare+Choice Program*, 24 HEALTH CARE FIN. REV. 83 (Fall 2002).

[105] *See* HHS, *supra* note 95, § 6, at 43-54 (entitled "Medicare + Choice Plans"); Pizer 4/23 at 144; Pizer Presentation, *supra* note 104, at 2; Pizer & Frakt, *supra* note 104, at 83.

enrollees in December 1999.[106] Congress added a new Part D to Medicare as part of the MMA. Part D will provide some coverage for prescription drugs for certain eligible enrollees.[107]

According to the 2004 Medicare trustees report, the program is unsustainable in its current form.[108] The unfunded obligations of the program currently exceed $6 trillion, and the Part A trust fund is projected to be exhausted in 2019.[109] The trustees report indicates that the Part A trust fund can be restored to actuarial balance "by an immediate 108 percent increase in program income or an immediate 48 percent reduction in program outlays (or some combination of the two)," with far greater adjustments necessary if changes are delayed or phased in.[110]

MA plans also have had difficulties.[111] One speaker stated that the program was a failure because of pricing problems and "incredible inflexibilities in the administration of the program."[112] Another speaker disagreed that Medicare Plus Choice was a complete failure, but noted that it is far from what it could have been.[113] One panelist testified that although the Medicare program has attempted to introduce competitive pricing to set the rates the government pays to MA plans, to date none of those efforts has been successful.[114] As a result, Medicare continues to establish the payment rates administratively. According to this speaker, to the extent plans compete, it typically has been on the benefits they provide.[115] This speaker discussed some of his empirical research findings, which show that in counties with multiple MA plans competing for beneficiaries, the plans competed based upon premiums paid by Medicare

---

[106] Pizer & Frakt, *supra* note 104, at 83 & n.1.

[107] Pub. L. No. 108-173.

[108] 39 BOARDS OF TRUSTEES OF THE FEDERAL HOSPITAL INSURANCE & FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUNDS ANN. REP. 1-21 (2004) (§ I, Overview) [hereinafter 2004 MEDICARE TRUSTEES REPORT], *at* http://www.cms.hhs.gov/publications/trusteesreport/2004/tr.pdf.

[109] 2004 MEDICARE TRUSTEES REPORT, *supra* note 108, at 2 ("The financial status of the fund has deteriorated significantly, with asset exhaustion projected to occur in 2019 under current law compared to 2026 in last year's report.").

[110] Social Security & Medicare Trustees, *Status of the Social Security and Medicare Programs: A Summary of the 2004 Annual Reports*, http://www.ssa.gov/OACT/TRSUM/trsummary.html (last visited July 15, 2004).

[111] Antos 9/30 at 121.

[112] *Id.* at 122.

[113] Francis 9/30 at 128.

[114] Pizer 4/23 at 147.

[115] *Id.* at 147.

beneficiaries and extra benefits.[116]

The Medicare program has a significant effect on the overall U.S. health care market. As one panelist remarked, "Medicare's administrative requirements shape the business environment for everybody in the health care sector … and changes to the Medicare program have spillover effects on the rest of the market."[117] He stated that some Medicare policies, such as hospital prospective payment, have improved the health care system and benefitted consumers.[118] Nonetheless, he argued that Medicare policy more often than not fails "to promote innovation and efficiency in the health care sector."[119] As he explained, "Medicare and Medicaid continue to rely on regulation and micro-management rather than competition and consumer choice," undermining both the ability and willingness of providers to compete.[120] Another speaker noted that because hospitals have to abide by Medicare's rules for their Medicare patients, those rules end up governing how hospitals do business in the private sector as well.[121]

Most panelists noted that there are good aspects to the Medicare program, but suggested that it should be significantly reformed.[122] Several speakers stated that Medicare impedes innovation in health care.[123] For example, one speaker explained that Medicare regulations prohibit paying for a physician visit unless the physician physically sees the patient. This rule has an important anti-fraud rationale, but it creates difficulties when services are more efficiently delivered without this requirement. For example, a consultation between a rural general practitioner and an urban specialist might be beneficial to the patient, but it is less likely to occur if the urban specialist cannot bill for his services unless the patient travels to his office.[124]

Several speakers noted that the Medicare prescription drug benefit will be helpful to beneficiaries, because it will help in the management of chronic illness, and fills an obvious gap

---

[116] *Id.* at 158 (noting that the amount of competition in any given county also affected new entry; *i.e.*, the more competing plans, the less likely entry would occur).

[117] Antos 9/30 at 115.

[118] *Id.* at 115. *See also* Crippen 9/30 at 155.

[119] Antos 9/30 at 115, 124.

[120] *Id.* at 116, 122.

[121] Francis 9/30 at 131.

[122] *See, e.g.*, Antos 9/30 at 116, 121-23; Francis 9/30 at 132-37, 141-42; Lemieux 9/30 at 144, 146-47.

[123] Francis 9/30 at 135-36; Antos 9/30 at 115, 124; Lemieux 9/30 at 147-53.

[124] Francis 9/30 at 135.

in the benefit package.[125] Some expressed concern, however, about the risks for innovation if the Centers for Medicare & Medicaid Service (CMS) start setting pharmaceutical prices.[126]

One speaker suggested that the federal government should reform Medicare to look more like the Federal Employees Health Benefits Program (FEHBP), which would empower consumers and have positive spillover effects on the broader health care market.[127] He and others claim such an approach would rely on "consumer choice in a sensible way, with good, solid federal oversight" to protect consumers.[128] Another speaker agreed that there were profound differences between FEHBP and Medicare because the government relied on competition in FEHBP and on administratively designed benefits and delivery arrangements in Medicare, with the result that FEHBP beneficiaries have had catastrophic and prescription drug coverage for many years, while Medicare beneficiaries only recently got both.[129] According to this speaker, Medicare's legislative and regulatory requirements make it extremely difficult for CMS to adapt the program to changes in health care delivery and standards.[130]

B. Medicaid

In 1965, the Medicaid program was established to provide health care coverage for certain low-income families, as well as certain low-income aged, blind, and disabled individuals.[131] The federal government sets eligibility and service parameters for the Medicaid program, and the states specify the services they will offer and the eligibility requirements for enrollees, and administer the program.[132] As a result, Medicaid programs vary from state to state. Costs are shared between the federal and state governments, with federal contributions varying based on the wealth of the state and the amounts the state contributes toward the

---

[125] Lemieux 9/30 at 145-46, 150; Francis 9/30 at 136-37.

[126] Antos 9/30 at 125-26 (cautioning that short-term low prices are "seductive if you're looking at big budget deficits," but could discourage long-term investment and innovation); Lemieux 9/30 at 151. *See also infra* Chapter 7. *But see* CENTERS FOR MEDICARE & MEDICAID SERVICES, PUB. NO. CMS-11054, THE FACTS ABOUT UPCOMING NEW BENEFITS IN MEDICARE (2004), *available at* http://www.medicare.gov/Publications/Pubs/pdf/11054.pdf (noting that the MMA specifically bars CMS from negotiating drug prices).

[127] Antos 9/30 at 122-23.

[128] *Id.* at 122-23.

[129] Francis 9/30 at 185-87.

[130] *Id.* at 128-37, 186-87. *See also* Antos 9/30 at 121-22; Lemieux 9/30 at 144-47.

[131] 42 U.S.C. § 1396 *et. seq*. *See also* CMS, *supra* note 92.

[132] CMS, *supra* note 92.

program.[133]

Medicaid programs generally cover young children and pregnant women whose family income is at or below 133 percent of the Federal poverty level, as well as some low-income elderly and disabled adults.[134] A recipient's resources also must be limited. The scope of services provided to Medicaid recipients includes: inpatient and outpatient hospital services, prenatal care, childhood vaccines, physician services, and nursing facilities services for persons aged 21 or older.[135]

In 2002, total Medicaid enrollment was 50.8 million, up from 44.2 million in 2000. Of the 50.8 million enrollees, 25.5 million were non-disabled children, 12.9 million were non-disabled, non-aged adults, 7.9 million were disabled, and 4.5 million were aged.[136] Children and adults who are not disabled or aged accounted for the greatest enrollment increases.[137] Total Medicaid spending increased 25 percent, from $205.8 billion in 2000 to $257.6 billion in 2002.[138] Increased spending for aged and disabled individuals accounts for almost 60 percent of this spending increase, and these individuals account for over 70 percent of all Medicaid spending and 85 percent of spending for prescription drugs.[139]

Most states have enrolled a substantial majority of their Medicaid population in some

---

[133] *See* CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS), MEDICAID: A BRIEF SUMMARY, *at* http://www.cms.hhs.gov/publications/overview-medicare-medicaid/default4.asp (last modified Jan. 28, 2004).

[134] *See Id.* Generally, programs will cover those who meet one of the following criteria: (1) meeting the requirements for the Aid to Families with Dependent Children (AFDC) program that were in effect in the state on July 16, 1996; (2) children under age 6 whose family is at or below 133 percent of the Federal poverty level; (3) pregnant women whose family income is below 133 percent of the federal poverty level; (4) Supplemental Security Income (SSI) recipients in most states; (5) recipients of adoption or foster care assistance; (6) certain protected groups who are permitted to keep Medicaid benefits for a limited period of time (*e.g.*, individuals who are disqualified for cash assistance due to worker income from other sources); and (7) all children born after September 30, 1983, under age 19, whose families' income is at or below the federal poverty level. *Id.*

[135] *See Id.* Other Medicaid services may include family planning services and supplies, rural health clinic services, home health care for persons eligible for skilled-nursing service, laboratory and x-ray services, pediatric and family nurse practitioner services and nurse-midwife services, and early and periodic screening, diagnostic, and treatment services for children under age 21. *Id.*

[136] JOHN HOLAHAN & BRIAN BRUEN, MEDICAID SPENDING: WHAT FACTORS CONTRIBUTED TO THE GROWTH BETWEEN 2000 AND 2002? 4 (Kaiser Comm'n on Medicaid & the Uninsured, Issue Paper Pub. No. 4139, 2003), *available at* http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=22135.

[137] *Id.* at 4.

[138] *Id.* at 3.

[139] *Id.* at 2, 8. In 2002, Medicaid paid approximately $92.3 billion (out of $257.6 billion in total spending) for long term care. *Id.* at 7.

form of managed care.[140] Many states have obtained waivers from CMS, authorizing experimental demonstration projects to cover uninsured populations and to test new delivery systems.[141]

C. Other Public Programs

In 1997, as part of the Balanced Budget Act, Congress created title XXI, the State Children's Health Insurance Program (SCHIP).[142] SCHIP "was designed as a Federal/State partnership, similar to Medicaid, with the goal of expanding health insurance to children whose families earn too much money to be eligible for Medicaid, but not enough money to purchase private insurance."[143] SCHIP gives grants to states to provide health insurance coverage for uninsured children in families with income up to 200 percent of the federal poverty level.[144] In 2003, 5.8 million children were enrolled in SCHIP at some point during the fiscal year, up from 5.3 million children in 2002.[145]

Uninsured children who are not eligible for Medicaid, under age 19, and who are at or below 200 percent of the federal poverty level meet the federal eligibility criteria for SCHIP.[146] Although states are allowed to impose cost sharing provisions, such as premiums, deductibles, or fees for some services, states cannot impose cost-sharing for pediatric preventative care or immunizations, or in amounts that exceed 5 percent of a family's gross or net income.[147]

States have the option whether to participate in SCHIP, and if they do, they may provide coverage by expanding Medicaid, expanding or creating a state children's health insurance

---

[140] *See* CMS, *supra* note 133.

[141] *Id.* These waivers are authorized by the Social Security Act § 1115.

[142] *See* Centers for Medicare & Medicaid Services (CMS), *Welcome to the State Children's Health Insurance Program*, *at* http://www.cms.hhs .gov/schip/about-SCHIP.asp (last visited June 23, 2004). *See also* American Academy of Pediatrics, *The State Children's Health Insurance Program*, *at* http://www.aap.org/advocacy/schipsum.htm (last visited June 23, 2004).

[143] *See* CMS, *supra* note 142.

[144] *Id.* News Release, U.S. Dep't of Health & Human Services (HHS), SCHIP Provided Health Coverage to 5.8 Million Children in 2003 (Feb. 12, 2004) ("The SCHIP law authorized $40 billion in federal funds over 10 years to improve children's access to health coverage."), *at* http://www.hhs.gov/news/press/2004pres/20040212.html. SCHIP spending limits for fiscal years 1998 through 2007 are as follows: $4,295 billion for FY 1998; $4,275 billion for FY 1999 through FY 2001; $3,150 billion for FY 2002 through FY 2004; $4,050 billion for FY 2005 through FY 2006; and $5 billion for FY 2007. CMS, *supra* note 142.

[145] HHS News Release, *supra* note 144.

[146] *See* American Academy of Pediatrics, *supra* note 142.

[147] *See* CMS, *supra* note 142; American Academy of Pediatrics, *supra* note 142.

program, or some combination of both. As of September 30, 1999, all states and U.S. territories had an approved SCHIP plan.[148] States also can spend up to 10 percent of the funds to provide coverage through a community-based health delivery system or by purchasing family coverage.[149]

Like Medicaid, states have enrolled many of their SCHIP participants in managed care. The states administer SCHIP under Medicaid rules or by using alternative health insurance plans that meet the actuarial value of certain key health services.

There are a number of additional public programs that provide care to specific categories of individuals.[150] TRICARE/CHAMPUS is a military health care program for active duty and retired members of uniformed services, their families, and survivors. The Department of Veterans Affairs provides medical assistance to eligible veterans. The Indian Health Service (IHS) provides medical assistance to eligible American Indian and Alaska Native people at IHS facilities.

VII. PPOS

More than 100 million Americans receive their health care benefits through a PPO, whose structure and operation vary.[151] PPO health benefit options are "a configuration of benefit design features offered through a contracted network [that] may be assembled in a fully customized fashion by a self-funded employer or offered by an insurance carrier that develops network-based products that are sold to customers on an insured basis."[152] Providers, independent companies, and hospital systems mostly own these networks, which they establish by contracting with a variety of providers, who typically are paid on a discounted FFS basis.[153]

---

[148] *See* CMS, *supra* note 142.

[149] *See Id. See also* American Academy of Pediatrics, *supra* note 142.

[150] *See generally* U.S. Census Bureau, *Types of Health Insurance Coverage*, *at* www.census.gov/hhes/hlthins/hlthinstypes.html (last revised Apr. 21, 2004).

[151] Robert E. Hurley et al., *The Puzzling Popularity of the PPO*, 23 HEALTH AFFAIRS 56, 58 (Mar./Apr. 2004); Andrew I. Batavia, *Preferred Provider Organizations: Antitrust Aspects and Implications for the Hospital Industry*, 10 AM. J.L. & MED. 169, 175 (1984). *See also* Eric R. Wagner, *Types of Managed Care Organizations*, *in* ESSENTIALS OF MANAGED HEALTH CARE 21 (Peter R. Kongstvedt ed., 4th ed. 2003); Dechene, *supra* note 18, § 2.1, at 2-3 to 2-5; Lerner 4/24 at 96-98 (listing many types of PPOs).

[152] Hurley et al., *supra* note 151, at 58.

[153] SHERMAN FOLLAND ET AL., THE ECONOMICS OF HEALTH AND HEALTH CARE 256 (2004); Stephen A. Norton & Stephen A. Zuckerman, *Reimbursement for Physician Services*, *in* INTEGRATING THE PRACTICE OF MEDICINE 78 (Ronald B. Connors ed., 1997) ("A recent study of 30 PPO plans indicates that the predominant payment method for PPO providers was discounted FFS and that none of the PPOs surveyed used capitation as a basic form of physician reimbursement."). Providers who contract for inclusion in a PPO include IPAs, medical

This section focuses on PPO health benefit options.[154]

PPOs first emerged in the early 1980s and have grown significantly in the intervening decades. One survey found that the number of PPOs increased sevenfold between 1987 and 1994.[155] Another survey found that the number of employees enrolled in PPOs doubled between 1994 and 2002, and that in 2002, 50 percent of all employees enrolled in health insurance used PPO products.[156] It is difficult to obtain precise and reliable data on the number of PPOs and their exact enrollment.[157] Commentators attribute PPOs' rapid expansion to private insurers' attempts to control spiraling medical costs, providers' defensive reactions to the growth of HMOs, and consumer and employer preferences for greater choice in selecting primary care and specialized physicians than many HMOs offered.[158]

Some commentators believe PPOs have had considerable success in obtaining volume discounts from physician-participants.[159] One study found that two national insurers offered physicians payments that on average were approximately 11 to 20 percent lower for PPO products than for their indemnity plans.[160] Another commentator stated that PPOs began by paying physicians about 20 percent less than their average charge, but some "more aggressive" payors have asked providers to accept a fixed discounted-fee schedule for all services, often

---

groups, individual physicians, hospitals, and other necessary facilities.

[154] For a discussion of physician network joint ventures, see *supra* Chapter 2.

[155] Norton & Zuckerman, *supra* note 153, at 78.

[156] Donald Crane, *Statement* 4 (5/7), *at* http://www.ftc.gov/ogc/healthcarehearings/docs/030507doncrane.pdf. *See also* S. Allen 4/25 at 105 (in Arkansas, BCBS has 71 percent of its business in PPOs).

[157] *See* Wu 4/23 at 128 (stating that it is hard to find accurate data on PPO enrollment because PPOs "lack many of the reporting and operating standards that [apply to] HMOs."); Timothy Lake, *Literature Synthesis: How Health Plans Select and Pay Health Care Providers in their Managed Care Networks* 14-15, *in* TIMOTHY LAKE ET AL., MEDICARE PAYMENT ADVISORY COMM'N, MPR No. 8568-700, HEALTH PLANS' SELECTION AND PAYMENT OF HEALTH CARE PROVIDERS, 1999 app.C (2000) (final report) ("Analysis of PPO networks are made even more complex by the prevalent practice of renting rather than owning networks, as well as the existence of national and local independent PPOs that rent out each other's services.").

[158] Dechene, *supra* note 18, § 2.1, at 2-3, § 2.2, at 2-5 ("Many [PPOs] were formed as a defensive alternative to the growth of HMOs. The initial physician-sponsored PPOs provided a vehicle by which physicians could continue to practice traditional fee-for-service medicine in a structure that could compete with other managed care organizations."); Desmarais 2/27 at 167; Kanwit 4/25 at 54-55.

[159] Norton & Zuckerman, *supra* note 153, at 78.

[160] Diana Verrilli & Stephen Zuckerman, *Preferred Provider Organizations and Physician Fees*, 17 HEALTH CARE FIN. REV. 3 (1996).

based on a Medicare fee schedule.[161]

Commentators state that most physicians are willing to accept the discounted fees that PPOs offer because they expect to obtain additional patients.[162] Many PPOs include a "rapid payment" clause for certain claims, which makes their plans more appealing to providers.[163] Two panelists noted that a consumer may end up paying higher prices if their physician ceases to participate in the PPO but the consumer continues to see that physician.[164] Some panelists noted that physicians typically participate in multiple PPO and HMO plans, which can increase contracting costs.[165]

Commentators question whether PPOs provide sufficient incentives for the delivery of cost-effective care.[166] A panelist observed that consumers enrolled in PPOs can easily refer themselves to specialists, which can lead to excess costs.[167]

Some commentators believe that PPOs can improve quality of care by implementing utilization review, creating clinical protocols, and using credentialing.[168] Although PPOs can undertake these steps on their own, payors are encouraging such strategies with economic

---

[161] Dechene, *supra* note 18, § 2.4.2.4, at 2-13. PPOs turn to external benchmarks such as the Medicare fee schedule because "[m]any providers have marked up their list prices [in recent years] so that the discounted prices do not represent much reduction at all." *Id.* at § 2.1, at 2-3.

[162] *See* FOLLAND ET AL., *supra* note 153, at 257 ("[T]he provider may enjoy a large increase in patient care business by joining the network."); Norton & Zuckerman, *supra* note 153, at 78. Physicians also may agree to contracts with discounted fees to avoid losing patients.

[163] FOLLAND ET AL., *supra* note 153, at 257; Wagner, *supra* note 151, at 21.

[164] *See* Crane 5/7 at 36; Feder 2/27 at 223.

[165] Each PPO has its own administrative and utilization requirements, and physicians must comply with all of the requirements to be paid. Edward B. Hirshfeld & Gail H. Thomanson, *Medical Necessity Determinations: The Need for a New Legal Structure*, 6 HEALTH MATRIX 3, 32-33 (1996); Casalino 9/25 at 16 (stating that it is difficult for physicians in solo or small group practice who contract with multiple HMOs to comply with each HMO's utilization management process).

[166] Batavia, *supra* note 151, at 175-76; Dechene, *supra* note 18, § 2.4.2.4, at 2-13 ("While a discounted-fee schedule can be an important cost containment tool, it may be less effective than other payment mechanisms, especially capitation, used by HMOs."); Burgess 4/9 at 107-108 (stating that FFS creates incentives to overprovide health care services).

[167] Crane 5/7 at 38 (observing that PPO "enrollees are allowed to directly refer to specialists. And, so, you can't have precisely the same utilization controls.").

[168] Peter R. Kongstvedt, *Compensation of Primary Care Physicians*, *in* ESSENTIALS OF MANAGED HEALTH CARE, *supra* note 151, at 85, 92 (discussing credentialing) [hereinafter Kongstvedt, *Compensation*]; Peter R. Kongstvedt et al., *Using Data and Provider Profiling in Medical Management*, *in* ESSENTIALS OF MANAGED HEALTH CARE *supra* note 151, at 379.

incentives tied to various quality measures.[169] Others question whether PPOs can improve quality, contending that PPOs may not be able to encourage or compel changes in physician behavior.[170] They also argue that PPOs may not have sufficient access to quality-related data to implement certain care quality systems because "PPO participants are free to use out-of-network providers and no specific physician is responsible for all of their care."[171]

VIII. THE UNINSURED

Approximately 15 percent of the population, or 44 million Americans, were uninsured at some point during 2002.[172] This section of the report describes the demographics of the uninsured, the impact of being uninsured, and the competitive implications of these facts.

There is no legal obligation to purchase health insurance. Some individuals can afford to purchase health insurance, but voluntarily elect to bear the risk of not doing so.[173] For many others, health insurance is prohibitively expensive when weighed against the cost of food, shelter, and basic necessities.[174]

---

[169] *See* Buxton 5/8 at 99 (stating that Blue Cross and other payors are working on the use of tiered fees for physicians to encourage higher quality outcomes and also stating that such incentives are "the wave of the future."); Kongstvedt, *Compensation*, *supra* note 168, at 137; Burgess 4/9 at 107-108 (noting some economists argue that a mix of FFS and capitation helps balance incentives to under and over-use health care services). For further discussion of P4P programs, see *supra* Chapters 1 and 3.

[170] *See* Marren 5/8 at 79-80; Weis 5/8 at 74; Hurley et al., *supra* note 151, at 65-67.

[171] *See* Hurley et al., *supra* note 151, at 65; *but see* Dechene, *supra* note 18, § 2.4.2.3, at 2-12 (contending that provider-initiated PPOs may have greater access to performance related data).

[172] MILLS & BHANDARI, *supra* note 2 at 1, 4. This figure is the Census Bureau's estimate of the number of Americans who are without health insurance *at some point during the year.* This estimated figure varies significantly, however, depending on the time period employed and the survey data that is used. *See Myths about the Uninsured: Hearing on the Uninsured Before the Health Subcomm., House Comm. On Ways and Means*, 108th Cong. (2004) (Statement of Len M. Nichols, Vice President, Center for Studying Health System Change) [hereinafter Nichols Statement], *at* http://waysandmeans.house.gov/hearings.asp?formmode=view&id=1226; IOM, *supra* note 30, at 3 ("Estimates of the number of persons who lack insurance vary depending on the survey …. Surveys differ in their size and sampling methods, the ways in which questions are asked about insurance coverage, and the period over which insurance coverage or uninsurance is measured.").

[173] Uwe E. Reinhardt, *Is There Hope for the Uninsured?*, 2003 HEALTH AFFAIRS (Web Exclusive) W3-376, 378-79 ("Not all 'uninsured' people, for example, represent a social problem in the sense that they are helpless victims of circumstance and require help from other members of society."), *at* http://content.healthaffairs.org/cgi/reprint/hlthaff.w3.376v1.pdf. *See also* Pauly 2/26 at 88 ("One fact is there are a lot of low-income people who have a lot better things to do with their money than spend it on health insurance, and … [t]here are a lot of people who don't value insurance as much as it costs. So, they don't buy it for various reasons.").

[174] *See* INSTITUTE OF MEDICINE, HIDDEN COSTS, VALUE LOST: UNINSURANCE IN AMERICA 43 (2003) ("Food, shelter, transportation, and clothing account for 85 percent on average of the expenditures of families living without health insurance.").

The uninsured cut across a large swath of the United States: some are young and healthy, some are not; many are below the poverty line and others are reasonably wealthy. Those most likely to lack health insurance are young adults (18 to 24 years old), people with less education, and Hispanics.[175] In 2002, 23.5 percent of the uninsured were in households with annual incomes of less than $25,000; 8.2 percent were in households with annual incomes of $75,000 or more.[176] The uninsured population is large, but fluid. A substantial majority of those currently uninsured will not be uninsured a year from now; a Congressional Budget Office study found that 45 percent of the uninsured were without coverage for four months or less and only 16 percent (or approximately 6.9 million Americans) remained uninsured for more than 2 years.[177] A second study suggests that approximately 12 percent of the uninsured remain so for more than four years.[178]

A. What Is the Impact of Not Having Insurance?

Being uninsured has significant health and financial consequences. Numerous studies indicate that being uninsured reduces consumption of health care services and products.[179] The uninsured are less likely to have a regular source of care, less likely to have had a recent physician visit, less likely to use preventive services, and more likely to delay seeking treatment.[180] One study indicates that those who are uninsured for a full year receive about half

---

[175] MILLS & BHANDARI, *supra* note 2; *See also* CONGRESSIONAL BUDGET OFFICE (CBO), HOW MANY PEOPLE LACK HEALTH INSURANCE AND FOR HOW LONG? 2 (2003), *available at* ftp://ftp.cbo.gov/42xx/doc4210/05-12-Uninsured.pdf.

[176] MILLS & BHANDARI, *supra* note 2, at 2 tbl.1, 6 fig.2, 7. Another way to look at the characteristics of the uninsured is as a percentage of the federal poverty level: 45 percent of the uninsured are within 100 to 300 percent of the federal poverty level, 36 percent are less than 100 percent of the federal poverty level, and 19 percent have incomes above 300 percent of the poverty level. In 2001, a family income of three hundred percent of poverty was $42,384. Reinhardt, *supra* note 173, at 379-80. *Cf.* JOHN HOLAHAN ET AL., THE NEW MIDDLE-CLASS OF UNINSURED AMERICANS – IS IT REAL? 2 (Kaiser Comm'n on Medicaid & the Uninsured, Issue Paper Pub. No. 4090, 2003).

[177] Pamela Farley Short & Deborah R. Graefe, *Battery-Powered Health Insurance? Stability in Coverage of the Uninsured*, 22 HEALTH AFFAIRS 244, 247-48 (Nov./Dec. 2003); CBO, *supra* note 175, at viii fig.S2, 9 tbl.3.

[178] Short & Grafe, *supra* note 177, at 247.

[179] *See* IOM, *supra* note 30; INSTITUTE OF MEDICINE, CARE WITHOUT COVERAGE: TOO LITTLE, TOO LATE (2002) [hereinafter IOM, WITHOUT COVERAGE]; INSTITUTE OF MEDICINE, HEALTH INSURANCE IS A FAMILY MATTER (2002) [hereinafter IOM, FAMILY MATTER]. The IOM reports consolidate and critically appraise the evidence and research regarding the impact of uninsurance on individuals and communities.

[180] AMERICAN COLLEGE OF PHYSICIANS, NO HEALTH INSURANCE? IT'S ENOUGH TO MAKE YOU SICK: LIST OF REFERENCES AND ABSTRACTS 4-5 (1999), *at* http://www.acponline.org/uninsured /lack-refs.pdf (citing, *e.g.*, Marc L. Berk et al., *Ability to obtain health care: recent estimates from the Robert Wood Johnson Foundation National Access to Care Survey*, 14 HEALTH AFFAIRS 139 (Fall 1995); Andrew B. Bindman et al., *Preventable Hospitalizations and Access to Care*, 274 JAMA 305 (1995); B. BLOOM ET AL., ACCESS TO HEALTH CARE PART 2:

as much care in dollar terms ($1,253) per person as the privately insured ($2,484).[181] A wide variety of adverse health consequences are associated with being uninsured.[182]

One study cautions that there is little evidence on whether the association between health insurance and health status is causal.[183] Research examining this point shows that health improvements have occurred for children and seniors under policies that expanded Medicaid, children's health, and Medicare coverage, but the evidence for non-elderly adults is less conclusive.[184]

Medical treatment for the uninsured is often more expensive than care of the insured because the uninsured are more likely to delay treatment and receive care in an emergency department.[185] Although one study suggested that the marginal cost of providing care in an

---

WORKING-AGE ADULTS (Nat'l Ctr. for Health Statistics, Vital Health Stat. Series 10, No. 197, Dep't of Health & Human Services Pub. No. (PHS) 97-1525, 1997); Helen R. Burstin et al., *The Effect of Change of Health Insurance on Access to Care*, 35 INQUIRY 389 (1998-99); John A. Ayanian et al., *Unmet Health Needs of Uninsured Adults in the United States*, 284 JAMA 2061 (2000)).

[181] *See* Jack Hadley & John Holahan, *How Much Medical Care Do The Uninsured Use, And Who Pays For It?*, 2003 HEALTH AFFAIRS (Web Exclusive) W3-66, 70, *at* http://content.healthaffairs.org/cgi/reprint/hlthaff.w3.66v1.pdf. The article notes that some of the difference is attributable to differences in age and health status between the insured and uninsured, but "research that takes these factors into account still finds about a 50 percent differential." *Id.* at 70.

[182] For example, the uninsured have worse medical outcomes and higher in-hospital mortality. *See* JACK HADLEY, THE KAISER COMM'N ON MEDICARE & THE UNINSURED, SICKER AND POORER: THE CONSEQUENCES OF BEING UNINSURED 4, fig.7 (2002) (finding that research published in the past 25 years suggests that having health insurance reduces mortality rates by 10 to 15 percent), *at* http://www.kff.org/uninsured/upload/13970_1.pdf; IOM, WITHOUT COVERAGE, *supra* note 179, at 4-5; IOM, *supra* note 174, at 3 ("The relative mortality rate for the insured and uninsured reflect a 25 percent higher mortality rate within the uninsured population."); Colleen Berry & Julie Donohue, *The Uninsured in the U.S.: An Issue Brief*, 1 HARVARD HEALTH POL'Y REV. (Fall 2000), *available at* http://hcs.harvard.edu/~epihc/currentissue/fall2000/barry.html; John Billings et al., *Recent Findings on Preventable Hospitalizations*, 15 HEALTH AFFAIRS 239 (Fall 1996); A.B. Bindman et al., *Preventable Hospitalizations and Access to Health Care*, 274 JAMA 305 (1995); P.D. Sorlie et al., *Mortality in the Uninsured Compared with that in Persons with Public and Private Health Insurance*, 154 ARCH. INTERN. MED. 2409 (1994).

[183] HELEN LEVY & DAVID MELTZER, WHAT DO WE REALLY KNOW ABOUT WHETHER HEALTH INSURANCE AFFECTS HEALTH? 33 (Economic Research Initiative on the Uninsured, Working Paper No. 6, 2001), *reprinted in* HEALTH POLICY AND THE UNINSURED (Catherine McLaughlin ed. 2004), *available at* http://www.umich.edu/~eriu/pdf/wp6.pdf.

[184] LEVY & MELTZER, *supra* note 183, at 34. *See also* Economic Research Initiative on the Uninsured, *Research Highlight No. 2, Q&A with David Meltzer, M.D., Ph.D.* (Mar. 2003), *at* http://www.umich.edu/~eriu/qa-meltzer.html; Nichols Statement, *supra* note 172, at 4 ("What has not been proved by this standard is that universal coverage would improve the health of *all* of the uninsured.").

[185] Levy 9/26 at 39 (noting that when the uninsured do seek treatment, "acuity is greater and treatment is more complicated.")

emergency department was not that much higher than in an outpatient setting,[186] hospitals have typically billed the uninsured full price for the services they received, instead of the discounted prices that hospitals offer insured patients.[187] Pursuant to Department of Health and Human Services (HHS) Secretary Tommy Thompson's direction, CMS and the Office of Inspector General of HHS issued guidance clarifying that hospitals can provide discounts to uninsured patients who cannot afford their hospital bills without violating Medicare payment rules.[188]

B. Who Pays for Health Care for the Uninsured?

The uninsured and their families bear some of the costs for their health care. One study found that uninsured persons experiencing severe health problems had higher out-of-pocket spending ($4,576 versus $1,912) and higher total medical spending ($42,166 versus $26,957) than did the insured.[189]

In many instances, the uninsured cannot pay for the care they receive. The burden of providing this uncompensated care varies tremendously. Only 7.9 percent of the population is uninsured in Minnesota, while in Texas, almost 25 percent of the population is uninsured.[190] Hospitals bear the largest burden, because they must assess and stabilize all patients with an emergency medical condition, regardless of ability to pay.[191] Yet, even in the same geographic

---

[186] Robert M. Williams, *The Costs of Visits to Emergency Departments*, 334 NEW ENG. J. MED. 642 (1996).

[187] IOM, *supra* note 30, at 5. *See also* Milstein 5/29 at 272; Fraser 5/29 at 273 (discussing differences in hospital charges for the insured and uninsured as rack rates versus negotiated prices).

[188] The Office of the Inspector General, *Hospital Discounts Offered to Patients Who Cannot Afford to Pay Their Hospital Bills* (Feb. 2, 2004), *at* http://oig.hhs.gov/fraud/docs/alertsandbulletins/2004/FA021904hospitaldiscounts.pdf; Centers for Medicare & Medicaid Services, *Questions On Charges For The Uninsured* (Feb. 17, 2004), *at* http://www.cms.hhs.gov/FAQ_Uninsured.pdf. *See also* News Release, U.S. Dep't of Health & Human Services, Text of Letter from Tommy G. Thompson Secretary of Health and Human Services to Richard J. Davidson President, American Hospital Association (Feb. 19, 2004) (responding to letter inquiry from hospital association indicating that hospitals have been billing uninsured patients full charges, instead of offering discounts), *at* http://www.hhs.gov/news /press/2004pres/20040219.html.

[189] James Smith, *Healthy Bodies and Thick Wallets: The Dual Relation between Health and Economic Status*, 13 J. ECON. PERSP. 145, 154 tbl.3 (1999). The study found no statistically significant difference in the wealth effects of the illness on the insured and uninsured. *Id.* Similarly, another study found non-statistically significant differences in the wealth impact on the insured and uninsured of being diagnosed with a serious illness (cancer, diabetes, heart attack, chronic lung disease, and stroke). *See* HELEN LEVY, THE ECONOMIC CONSEQUENCES OF BEING UNINSURED (Economic Research Initiative on the Uninsured, Working Paper No. 12, 2002), *available at* http://www.umich.edu/~eriu/pdf/wp12.pdf.

[190] MILLS & BHANDARI, *supra* note 2, at 9-10, tbl.4.

[191] *See, e.g.*, M. Ryan 3/26 at 32 ("[W]ith a high incidence of uninsured patients, we can find that we have a high incidence of patients who become inpatients for whom there is little or no reimbursement. It creates a substantial drain on the hospital resources. Yet, there is no way that we can avoid those responsibilities and so we

area, the burden of providing uncompensated care varies significantly among hospitals.[192]

These costs are "absorbed by providers as free care, passed on to the insured via cost shifting and higher health premiums, or paid by taxpayers through higher taxes to finance public hospitals and public insurance programs."[193] One study estimated that the uninsured received almost $100 billion in care in 2001. Federal, state, and local governments paid for a majority of this amount, through a "maze of grants, direct provision programs, tax appropriations, and Medicare and Medicaid payment add-ons."[194] Yet, approximately $35 billion in completely uncompensated care was still delivered in 2001.[195] Hospitals provided 60 percent of total uncompensated care ($20.8 billion), and community health centers and physicians each provided 20 percent ($7.1 billion and $6.8 billion).[196] It is unclear how much of these costs are actually shifted to other payers.[197]

C. The Impact of Competition

Our health care system relies on hospitals, physicians, and clinics to provide uncompensated care to the uninsured. Competition may help address some problems of the uninsured, for example, by lowering the price of insurance coverage and medical care.[198]

---

provide care."). This obligation is imposed by the Emergency Medical Treatment and Active Labor Act. *See supra* Chapter 1.

[192] *See* David A. Hyman, *Hospital Conversions: Fact, Fantasy, and Regulatory Follies,* 23 J. CORP. L. 741, 758-60 (1998). Many people believe that nonprofit hospitals obtain a tax exemption because they provide charity care to the uninsured. In fact, in most states, nonprofit hospitals are not required to provide a specific amount of charity care to receive a tax exemption. *See id*; Kevin M. Wood, *Legislatively-Mandated Charity Care for Nonprofit Hospitals: Does Government Intervention Make any Difference?*, 20 REV. LITIG. 709 (2001); David A. Hyman, *The Conundrum of Charitability: Reassessing Tax Exemption for Hospitals*, 16 AM. J.L. & MED. 327, 332 (1990) ("A widely shared (but incorrect) position is that charitable equals charity.")

Several class action lawsuits were recently filed against a large number of nonprofit hospitals, alleging that they "have distorted the extent of their charity care while using punishing tactics to obtain payments from uninsured patients." *See* Holbrook Mohr, *Suit Alleges Lack of Charity at Nonprofit Hospitals*, WASH. POST, June 18, 2004, at E03.

[193] AMERICAN COLLEGE OF PHYSICIANS, *supra* note 180, at 1. *See also* Hadley & Holahan, *supra* note 181, at 79 n.1 ("'Uncompensated care' is defined as medical care the uninsured receive but do not pay for fully themselves. It includes reduced-fee care; charity care, for which the uninsured do not pay anything; and bad debts incurred by the uninsured.").

[194] Hadley & Holahan, *supra* note 181, at 78.

[195] *Id.* at 69 ex.2; IOM, *supra* note 174, at 5 tbl.ES1.

[196] Hadley & Holahan, *supra* note 181, at 70-71.

[197] IOM, *supra* note 174, at 55-58.

[198] See William M. Sage et al., *Why Competition Law Matters to Health Care Quality*, 22 HEALTH AFFAIRS 31, 35-36 (Mar./Apr. 2003).

Competition also may worsen the problems of the uninsured, however, by decreasing the ability of providers to cross-subsidize some products and services. Competition will not transfer resources to those who do not have them.[199] Proposals to address these matters should be carefully evaluated to ensure that the consequences of any reform are pro-competitive.

IX. CONSUMER-DRIVEN HEALTH CARE

Panelists discussed the disadvantages of the current health care system, and the potential benefits of a more consumer-driven health care system. For example, Former Speaker of the House Newt Gingrich spoke at the Hearings and observed that "a third party payment model is inherently conflict-ridden because you have the person receiving the goods not responsible, the person [providing the] goods confused about who they're responsible to, and the person who is paying the money irritated with both the provider and the patient."[200]

Speaker Gingrich stated that there are four drivers, to transforming the U.S. health care system: the health care system must emphasize patient safety and outcome; embrace information technology (IT), computing, and communications; focus on quality and a culture of quality; and center on the individual consumer.[201] When consumers have information and knowledge, they will be empowered to make real choices about their care and take responsibility for their choices.[202] Other panelists agreed that we need a more consumer-driven health care system,[203] and that there is considerable room for improvement in health care IT and consumer information.[204] Two panelists suggested that the government could play a role in creating an IT infrastructure.[205]

---

[199] *See* Pauly 2/26 at 87 ("What competition alone can never do, it can't get all or even most of the uninsured insured.").

[200] Gingrich 6/12 at 9.

[201] *Id.* at 10-13.

[202] *Id.* at 12-13. Speaker Gingrich noted that consumer choice also implies individual responsibility and accountability.

[203] *See* Lansky 6/12 at 70-72; David Lansky, *A person-centered view of consumer information in the health care marketplace* (6/12) (slides) [hereinafter Lansky Presentation], *at* http://www.ftc.gov/ogc/healthcarehearings/docs/030612lansky.pdf; Comstock 6/12 at 111-13; Darling 6/12 at 103-04.

[204] *See* Lansky 6/12 at 70-89 (reporting on findings from studies and surveys conducted by the Foundation for Accountability (FACCT)); Lansky Presentation, *supra* note 203, at 4-16; Comstock 6/12 at 110-11; Gingrich 6/12 at 51-52 ("Everybody ought to have an electronic health record. It ought to be compatible across all the systems. All the major providers of these kind of systems should be part of an open systems architecture ….").

[205] Lansky 6/12 at 87-88; Gingrich 6/12 at 56-60; Lansky Presentation, *supra* note 203, at 17-24. *See also* Antos 9/30 at 117-121 (noting that CMS has an enormous and potentially useful database of information, and although patient and provider privacy issues are important and need to be protected, CMS makes it extremely difficult for researchers, including consumer or business groups, to access it).

Consumer-driven health care relies on consumers to make their own decisions regarding the care they receive. Tax-advantaged savings accounts (Health Savings Accounts, Health Reimbursement Arrangements, and Flexible Spending Accounts) can be used to pay for out-of-pocket health care expenses with pre-tax dollars.[206] Commentators and panelists stated that when individuals are responsible for paying for their health care costs up to a certain amount, they are likely to become more health conscious and more value conscious about the health care products and services they are purchasing.[207] Panelists generally supported greater development of consumer-driven health care and individual health savings accounts, but agreed that clear, accurate, and easily accessible information will be necessary for consumers to make informed choices.[208] Panelists noted a number of other barriers to a consumer-driven health care system, including provider culture and misaligned financial incentives.[209]

In general, panelists agreed that the health care system has been designed around the

---

[206] NEWT GINGRICH ET AL., SAVING LIVES & SAVING MONEY 85 (2003). As of January 1, 2004, employees may contribute to health savings accounts that can earn tax free interest and be rolled over from year to year. The accounts, however, are only permitted in conjunction with eligible health insurance plans. Eligible plans must have an annual deductible of at least $1,000 for an individual and at least $2,000 for a family, but the sum of the annual deductible and the other annual out-of-pocket expenses (other than premiums) cannot exceed $5,000 for an individual or $10,000 for a family. *See* MMA § 1201; Health Savings Account, *Health Savings Account Learning Center*, *at* http://www.ehealthinsurance.com/ehi/Welcome.ds (last visited July 15, 2004).

[207] *See* Dwight McNeill, *Do Consumer-Directed Health Benefits Favor The Young And Healthy?*, 23 HEALTH AFFAIRS 186, 186, 191 (Jan./Feb. 2004) (noting that "[t]he espoused active ingredient of consumer-directed benefits is increased financial exposure to medical expenses to motivate consumers to be more prudent purchasers as they make price-sensitive choices" but that current limitations on such issues as investment and portability may limit their effectiveness); Jon R. Gabel et al., *Consumer-Driven Health Plans: Are They More Than Talk Now?*, 2002 HEALTH AFFAIRS (Web Exclusive) W395, 396 ("At its heart, the consumer-driven health care movement seeks to combine incentives with information to enable consumers to make informed choices about non-life-threatening health care."), *at* http://content.healthaffairs.org/cgi/reprint/hlthaff.w2.395v1.pdf; G. Kelly 6/12 at 36 (noting that "what is going to be important going forward is for the consumer to have value, which is the equation of both price and quality …. [W]hen you spend your own money, you do it wisely … I know, since it's money out of my own pocket, what is the best mixture of both price and quality. I'm not going to buy the most expensive thing out there, but at the same time I'm going to get the best deal for my money.").

[208] Comstock 6/12 at 108-10; Lansky 6/12 at 70-71, 73-79 (providing three examples (one personal, two based on his organization's focus group studies) of how consumers take control or express the desire for more control by having access to more information); Lansky Presentation, *supra* note 203, at 3, 5-21; National Women's Law Center, *Comments Regarding Health Care and Competition Law and Policy (Nov. 25, 2003)* 8 (Public Comment) (noting importance of consumer information, especially in connection with women's reproductive health services, including treatment options); Shoptaw 4/11 at 59 (suggesting there will be a shift toward new consumer-directed health care, including defined contribution and medical savings accounts); *but see* M. Young 6/12 at 97-98 (noting that "many employers will embrace consumer-driven plans …. not because they philosophically believe it's the right thing, but quite frankly because they have no other options and they are desperate").

[209] *See* Comstock 6/12 at 108, 111-13. *See also* Jon R. Gabel et al., *Employers' Contradictory Views About Consumer-Driven Health Care: Results from a National Survey*, 2004 HEALTH AFFAIRS (Web Exclusive) W4-210, 214, 217 & 218 n.13 (noting the first evaluations of employers' views about consumer-driven health care's impact are ambiguous), *at* http://content.healthaffairs.org/cgi/content/full/hlthaff.w4.210v1/DC1; MARK A. HALL, MAKING MEDICAL SPENDING DECISIONS: THE LAW, ETHICS AND ECONOMICS OF RATIONING MECHANISMS (1996).

preferences of payers, providers, and employers, and not consumers.[210] A more consumer-driven system has the potential to lower costs, increase quality, and enhance consumer welfare.

[210] *See* Lemieux 9/30 at 145-146; Francis 9/30 at 177, 180.